12. An add-on payment for the rental cost of a specialty bed, in an amount not to exceed $25.00 per day, will be allowed when the specialty bed is part of a written intensive treatment program for Stage III or IV pressure ulcers or healing after grafting or flap repair surgery. Prior written approval from the Department is required and the approved specialty bed rental reimbursement will be limited to 3 months. A one-time extension, not to exceed three-months, may be granted by the Department if the physician and provider provide evidence that the wound is healing, but has not completely healed. Specialty type beds for this purpose will include pressure reduction overlays/mattress, low-air loss therapy beds and/or air-fluidized therapy beds.

13. When establishing annual per diem rates, the total "add on" payments made to a facility during the time period covered by the cost report will be used as a credit adjustment to costs shown on the cost report.

14. For individuals dually-eligible for Medicare and Medicaid, who reside in a nursing facility and elect the Medicare hospice benefit, the Department of Social Services will pay room and board costs, as defined in the State Medicaid Manual under subsection 4308.2, directly to the Medicare certified hospice organization.

15. The Department may withhold payment to facilities for non-compliance with any provision of this plan.

Section E – Political Subdivision Funding Pool

1. Government Nursing Facility Funding Pool. A government nursing facility funding pool is created to increase payment to nursing facilities that are owned by political subdivisions of the state (publicly owned) in proportion to their share of Medicaid days provided during the rate year. The pool is created subject to availability of funds and subject to the payment limits of 42 CFR §447.272 (Application of Upper Payment Limits – payments may not exceed the amount that can reasonably be estimated to be paid under Medicare payment principles).

2. Annual Computation of the Funding Pool: In summary, every nursing facility's Medicaid rate, per case mix classification, paid for the rate year, is compared to the calculated Medicare upper payment rate applicable to the same period for the same population. The difference between the Medicaid rate payment and the Medicare upper payment rate is then multiplied by the number of Medicaid days for the period, per nursing facility. The product is then summed for all nursing facilities with the total establishing the maximum funding pool which can be paid for the rate year. The pool calculation formula is as follows:

   a. Medicaid Average Payment. On a facility specific basis the department will determine the average payment to a long-term care nursing facility for the period. This will be a calculated payment rate determined by multiplying the number of total Medicaid days paid in each long-term care RUG case-mix classification times the facility average Medicaid per diem rate (to include unbundled ancillary services), for the period.
   b. Medicare Estimated Upper Payment Rate. In accordance with 42 CFR §447.272, the department will calculate the Medicare upper payment rate for long-term care nursing facilities in South Dakota. This calculation will include the Urban designations of Sioux Falls and Rapid City, and the Rural designations of all others. The calculation will use federal reimbursement guidelines, per payment period, to determine the maximum amount allowed to be paid to nursing facilities per 42 CFR §447.272.
   c. Case-Mix RUG's Crosswalk. The department will develop a Case-Mix RUG's (Resource Utilization Group) crosswalk between the South Dakota Long-Term Care Case-Mix RUG categories and the Federal Case-Mix RUG categories to establish an objective classification of similar populations. The crosswalk will be utilized in the comparison of the Medicaid payment and the calculated Medicare upper payment limit.

d. Funding Pool. The total difference calculated between the Medicaid average payment made and the calculated Medicare upper payment rate will create the funding pool.

3. Distribution of Funding Pool. Under the terms of South Dakota Codified Law, Chapter 28, each nursing facility owned by a political subdivision (publicly owned) is paid a portion of the funding pool. The amount of distribution is based on the ratio of the facility's Medicaid days to the total Medicaid days for all publicly owned facilities. The funding pool is calculated and distributed to each publicly owned nursing facility prior to October 1, of the calendar year following each state fiscal rate year.

4. Effective Date of the Government Funding Pool. The effective date of the government funding pool is established in accordance 42 CFR §447.256 (c) to be February 27, 2000. Effective for SFY 2001 and each year thereafter, subject to availability of funds and subject to the payment limits of 42 CFR §447.272, the department will calculate the funding pool for the period and make distribution in accordance with the plan provisions.

PART II

SOUTH DAKOTA STATE PLAN ATTACHMENT 4.19D
REIMBURSEMENT FOR NURSING FACILITIES
(STATE-OPERATED FACILITIES)

1. The purpose of this plan is to define the methodology for establishment of reimbursement rates for state-operated nursing facilities participating in the State's Medicaid program. Provisions of and payments under this reimbursement plan shall begin July 1, 1999.

2. A uniform report generated by the State's accounting system shall be submitted to the Department of Social Services within 30 days following the close of each facility's calendar quarter. The following criteria apply to all reports:

   a. Reports shall be completed in accordance with accounting procedures established by the State of South Dakota.

   b. Reports shall include costs allocated to each facility under the federally-approved Statewide Cost Allocation Plan.

   c. Reports shall include Department of Human Services administrative support costs allocated to each facility in accordance with that department's annual cost allocation plan submitted to and approved by the federal Department of Health and Human Services.

3. Facilities operating programs other than Medicaid-certified programs shall submit to the Department an annual cost allocation plan by August 1 of each year. This cost allocation plan will be the basis for allocation of costs among programs within a particular facility for the state fiscal year.

4. All providers shall be required to keep all financial and statistical records for a minimum of six years following the submission of accounting reports, and these records must be made available to representatives of the State and/or Department of Health and Human Services upon demand. In no instance shall records be destroyed when an audit exception is pending.

5. All accounting reports referenced in Provisions #2 and #3 shall be maintained in Department files for a minimum of six years or until any audit exceptions are cleared, whichever is longer.

6. Participation in the Medicaid program as a provider of nursing facility services shall be limited to those facilities that accept as payment in full the reimbursement established under this plan for the services covered by this plan.

7. Allowable costs are based upon criteria as defined in HCFA-15, Provider Reimbursement Manual, except as otherwise described in the plan. Allowable costs under this plan include the cost of meeting certification standards and routine services including, but not limited to room, board, nursing services, nursing supplies, therapy services, habilitation services, oxygen, medical equipment, catheters, catheter bags, special bed pads, supplies for incontinency, laundry of personal clothing, and all costs reflected on required accounting reports, as well as any other costs specifically listed in the plan.

8. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Additions to primary structures and/or major renovations may be reviewed individually and depreciated on the straight-line method. Generally accepted accounting procedures will be used in determining the life of any addition(s) to primary structures or major renovations. Depreciation on buildings shall be allowable only when funded, or when the proceeds are deposited to the State's General Fund. Funded depreciation can only be used for support of capital expenditures that will benefit Title XIX eligibles.

9. Depreciation on equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method for all such equipment presently in use at a facility. Equipment, furniture, automobiles, and specialized equipment purchased by the State for less than $25,000 and accounted for through the South Dakota budgetary accounting system shall be claimed and reported as a cost for the current period. Equipment, furniture, automobiles, and specialized equipment with an acquisition cost exceeding $25,000.00 must be depreciated according to generally accepted accounting procedures. Depreciation on equipment, furniture, automobiles, and specialized equipment shall be allowable only when funded, or when the proceeds are deposited to the State's General Fund.

10. One per diem rate shall be established for a facility and paid for every Medicaid-eligible resident in that facility. The State shall have discretion in what it charges non-Medicaid residents. The state will not pay for reserve bed days in state institutions.

11. No reimbursement shall be allowed for additional costs related to sub-leases.

12. Per diem rates shall be calculated on the basis of actual occupancy. Occupancy is defined as actual physical resident days.

13. A provisional per diem rate shall be established for the first quarter of each state fiscal year based upon each facility's operating budget and projected resident population. Provisional per diem rates shall be established for the second, third, and fourth quarters of each state fiscal year based upon actual allowable cost and actual physical resident days for the previous quarter. Allowances may be made for known future costs not incurred in the previous quarter if those costs will be incurred prior to the end of the subsequent quarter.

    OBRA-1987 cost requests (excluding costs associated with Nurse Aide Training) submitted per Department instructions and approved by the Department will be added to the facility's rate without subjection to ceilings.

14. Following the end of each quarter, the Department shall re-calculate the Medicaid rate from the reports submitted in accordance with Provisions #2 and #3. This rate shall be compared to the provisional rate paid for that quarter, and a financial adjustment shall be made to adjust for any over or under payments.

15. Field audits of accounting reports shall be conducted that shall meet or exceed the scope of Title XVIII specifications. All facilities shall be audited at a minimum of once every three years.

16. All audit exceptions shall be accounted for on the HCFA 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.

17. For facilities acquired through purchase or a capital lease on or after July 1, 1989, the buyer's or lessee's allowable historical cost of property is limited to the lower of the following:

a. The actual cost to the new owner;

b. The seller's or lessor's acquisition cost increased by the lesser of one-half of the percentage increase as contained in the "Dodge Construction System Costs for Nursing Homes," or one-half of the increase in the United States city average consumer price index for all urban consumers. Any additional allowable capital expenditures incurred by the buyer or lessee subsequent to the date of transaction shall be treated in the same manner as if the seller or lessor had incurred the additional capital expenditure. The allowable depreciation expense shall be calculated on the buyer's or lessee's allowable historical cost. In no case is interest expense excluding working capital interest allowed on a principal amount in excess of the buyer's or lessee's allowable historical expense.

18. The Department may withhold payment to facilities for non-compliance with any provision of this plan.

PART III

SOUTH DAKOTA STATE PLAN ATTACHMENT 4.19D
REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED UNDER 16 BEDS

1. The purpose of this plan is to define the methodology for the establishment of reimbursement rates for ICF/MR facilities under 16 beds participating in the State's Medicaid program. Provisions of and payments under this reimbursement plan shall begin July 1, 1999.

2. A uniform report furnished by the Department of Human Services, shall be completed and submitted to the Department within 138 days following June 30. The following criteria apply to all reports:

   a. Reports shall be completed following generally accepted accounting procedures and the accrual method of accounting.

   b. Reporting period shall cover the twelve month period, July 1 through June 30.

3. All providers shall be required to keep all financial and statistical records for a minimum of six years following the submission of cost reports and these records must be made available to the Department of Human Services and/or Medicaid Fraud Unit (MFCU) and/or Department of Health and Human Services (HHS) upon request. In no instance shall the records required by this paragraph be knowingly destroyed when an audit exception is pending.

4. All cost reports submitted will be maintained in Department files for a minimum of six years or until any audit exceptions are cleared, whichever is longer.

5. The provider shall identify all related organizations to whom reported operating costs were paid. Identification of the amount of these costs, the services, facilities, supplies furnished by or interest paid to a related organization shall be attached to the annual cost report. Costs shall not exceed the lesser of actual cost to the related organization or the open market cost.

6. Rent paid to a related organization shall be disallowed and actual cost of ownership shall be reported. For purposes of this plan, cost of ownership is defined as mortgage interest, plus depreciation on building(s), plus depreciation on equipment, plus repairs to building(s), plus repairs to equipment, plus insurance on building(s), plus insurance on equipment, plus property taxes.

7. Participation in the program as a provider of ICF/MR services shall be limited to those facilities that accept as payment in full the reimbursement established under this plan for services covered by the plan.

8. Allowable costs are based upon criteria as defined in HCFA-15, Provider Reimbursement Manual, except as otherwise described below.

Routine Services. Routine Services shall be defined as those services and items which are necessary in meeting the care of the residents. The following items and services will be considered to be routine for purposes of Medicaid costs reported.

a. All general nursing services, including administration of oxygen and medications; handfeeding; care of the incontinent; tray service; normal personal hygiene which includes bathing, skin care, hair care, nail care, shaving, and oral hygiene; enema; etc.;

b. Items which are furnished routinely and relatively uniformly to all residents, such as resident gowns, water pitchers, bedpans, etc.;

c. Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually or in small quantities, such as alcohol, applicators, cotton balls, Band-Aids, linen savers, colostomy supplies, catheters, catheter supplies (eg, bag), irrigation equipment, needles, syringes, I.V., equipment, T.E.D. hose, hydrogen peroxide, O-T-C enemas tests (Clinitest, Testape, Ketostix), tongue depressors, facial tissue, personal hygiene items (which includes soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouth wash, peri-care products, etc.);

d. Items which are utilized by individual residents but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, other durable medical equipment, etc.;

Social Services and Activities including supplies for these services;

e. At least 3 meals/day planned from the Basic food groups in quantity and variety to provide the medically prescribed diets. This includes special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as prescription item by a physician - as these supplements have been classified by the FDA as a food rather than a drug;

f. Laundry Services;

g. Active Treatment Services for developmentally disabled residents;

h. Therapy services;

i. Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and specialized wheelchair transportation services;

j. Oxygen, regulators, tubing, masks, tents, and other equipment necessary for the administration of oxygen; and

k. Oxygen concentrators.

Non-Routine Services. These services are considered ancillary for Medicaid payment. The costs of these services should be accounted per instructions for completing the cost report. Such billings are to be made by the supplier and not by the nursing facility. These services include, but are not limited to:

a. Prescription Drugs;

b. Physician services for direct resident care;

c. Laboratory and Radiology;

d. Mental Health Services;

e. Therapy services when provided by someone other than a facility employee; and

f. Prosthetic devices and supplies for prosthetic devices provided for an individual resident.

9. Building depreciation shall be limited to 3% on masonry and 4% on frame buildings and shall be calculated on the straight-line method. Generally accepted accounting procedures will be used in determining the life of any addition(s) to primary structures.

10. Depreciation on fixed equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item(s) purchased after January 1, 1987.

11. Depreciation on major movable equipment, furniture, automobiles, and specialized equipment shall be calculated on the straight-line method, following the American Hospital Association (AHA) Guidelines for any item purchased after January 1, 1987. Deviations from the AHA Guidelines may be granted in those instances in which facilities can provide the Department with documented historical proof of useful life.

12. Allowances may be made for known future costs due to new or revised federal or state laws, regulations and/or standards having an impact on costs incurred by long term care facilities. An explanation of costs of this nature must be attached to the Cost Report if they are to be given consideration.

13. Statewide averages and allowable per diem rates shall be set annually prior to July 1.

14. A per diem rate shall be established and paid for each Medicaid eligible resident in a facility.

15. In computing annual per diem rates, costs subject to the inflation shall be inflated on the basis of the United States Consumer Price Index as reflected by the forecasts received from DRI/McGraw Hill, Inc. each year.

16. Annual rates shall be established prior to July 1 of each year. Department rules, or policies, shall be final. Interim rate adjustments may be made for the following reasons only:

a. Adjustments for erroneous cost or statistical reporting discovered during the course of an audit;

b. New or revised federal or state laws, regulations and/or standards having an impact on costs effective during the twelve-month period for which rates have been established;

c. Special circumstances arise that warrant an interim rate adjustment. Requests for interim rate adjustments due to special circumstances shall be submitted in writing to, and shall be approved by, the Secretary of the Department of Human Services. Cost increases to meet existing laws or regulations or to provide appropriate care for residents admitted to a facility shall not justify an interim rate adjustment.

17. Provisional per diem rates shall be established for new providers, using 110% of the average rate of current providers. Providers experiencing new operational ownership shall receive the per diem rate of the previous owner.

18. For reimbursement purposes outlined under this plan, any lease agreement entered into by the operator and the landlord shall be binding on the operator or his successor(s) for the life of the lease, even though the landlord may sell the facility to a new owner. For reimbursement purposes outlined under this plan, the only exceptions for permitting the breaking of a lease prior to its natural termination date shall be:

a. the new owner becomes the operator; or,

b. the owner secures written permission from the Secretary of the Department of Human Services to break the lease.

19. No reimbursement shall be allowed for additional costs related to sub-leases.

20. The reimbursement rate for out-of-state facilities providing ICF/MR services to residents of the State of South Dakota shall be the lesser of the Medicaid rate established by the state in which the facilities are located or the average Medicaid rate for the bed size and type of service level applicable to in-state facilities.

21. The occupancy factor used in calculating per diem rates shall be the number of resident days recognized by the department upon completion of the desk audit.

22. The facility's records shall be audited annually by an independent accountant. The audit shall meet all the requirements of the Office Management and Budget Circular A-133 and be forwarded to the agency setting its rates.

23. All audit exceptions shall be accounted for on the HCFA 64 in accordance with the State Medicaid Manual, Part 1, Section 2500.

24. An "add on" payment will be allowed when the State Office of Adult Services and Aging makes a determination that a resident of an intermediate care facility for the developmentally disabled requires total parenteral or enteral nutritionally therapy and the resident is eligible for Medicaid but not eligible for Medicare. The amount of the "add on" will be $25.00 per day and will not be subject to any maximum or ceiling.

25. An add-on payment for the cost of ventilator equipment and supplies is allowed when a resident of an intermediate care facility for the developmentally disabled is ventilator dependent. A physician's order must document ventilator dependency.

26. When establishing annual per diem rates, the total "add on" payments made to a facility during the time period covered by the cost report will be used as a credit adjustment to dietary costs shown on the cost report. In addition, an adjustment will be made to dietary costs for known private pay residents receiving total parenteral or enteral nutritional therapy. The amount of the private pay adjustment will be equal to the "add on" payment established in section 26 and 27 multiplied by the number of days that private pay residents received total parenteral or enteral nutritional therapy or ventilator services.

27. The Department may withhold payment to facilities for non-compliance with any provision of this plan.

Enclosure 4

Attachment 4.19D

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.